

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN241AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2008
NAME OF PROVIDER OR SUPPLIER JOHNSON GROUP CARE #2		STREET ADDRESS, CITY, STATE, ZIP CODE 1240 E 10TH STREET RENO, NV 89512		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/14/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category I residents. The census at the time of the survey was six. Six resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Y 000		
Y 106 SS=D	449.200(2)(a) Personnel File - 1st aid & CPR NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Based on record review on 11/14/08, the facility failed to ensure 1 of 3 caregivers were trained in	Y 106		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 106	Continued From page 1 first aid and cardiopulmonary resuscitation (Employee #2). Severity: 2 Scope: 1	Y 106			
Y 898 SS=A	449.2744(1)(b)(4) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Based on record review on 11/14/08, the facility failed to ensure the medication administration record (MAR) was accurate for 1 of 6 residents (Resident #1). Severity: 1 Scope: 1	Y 898			
Y 922 SS=E	449.2748(3)(a) Medication Labeling NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be:	Y 922			

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Y 922	<p>Continued From page 2</p> <p>(a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician.</p> <p>This Regulation is not met as evidenced by: Based on observation on 11/14/08 the facility failed to ensure over-the-counter medications were labeled with the resident and physician names for 2 of 6 residents (Resident #2 and #6).</p> <p>Severity: 2 Scope: 2</p>	Y 922			

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